STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315015	A. BUILDING _____ B. WING _____	10/07/2020

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F 000	INITIAL COMMENTS SURVEY DATE: 09/30/2020 CENSUS: 107 SAMPLE SIZE: 22 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to a.) ensure that a resident was not in possession of a [redacted], b.) initiate a care plan (CP) for a resident who was identified as a [redacted], and c.) complete a [redacted] evaluation of the resident in a timely manner and in accordance with the facility policy. This	F 689	1. The lighter was confiscated from resident #63 and the resident was educated on the center policy of not keeping a personal [redacted] A [redacted] assessment was completed for resident #63 2. An audit of residents that [redacted] will be	10/30/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/16/2020

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F 689	Continued From page 1 deficient practice was identified for Resident #63, 1 of 1 resident reviewed for [redacted] and was evidenced by the following: During the tour of [redacted] Unit on 9/21/20 at 11:51 AM, the surveyor observed Resident #63 lying in bed watching television. The surveyor also observed an open pack of [redacted] and a [redacted] on the overbed table next to the resident's bed. The surveyor made the same observation on 9/24/20 at 10:18 AM. The surveyor noted that the resident's room was closed. The surveyor did not notice any residents walking about the unit. According to the Admission Record, Resident #63 was admitted with medical diagnoses that included: [redacted]. Review of the Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that Resident #63 was cognitively intact and had no behaviors. Review of Resident #63's CP which was initiated on [redacted], revealed a "Focus" area that indicted: "patient may [redacted] with supervision per [redacted] assessment." The CP further indicated to "monitor patient's compliance to [redacted] policy." During an interview with the Registered Nurse/Unit Manager (RN/UM) on [redacted] at 10:05 AM, the RN/UM stated that she recently started work on [redacted] unit in [redacted]. When questioned about the facility's [redacted] evaluation process, the RN/UM stated that residents were assessed on admission and as needed. The RN/UM explained that any resident	F 689	conducted to assure that a [redacted] assessment has been completed, a care plan has been initiated, and that residents that smoke do not have [redacted] in their possession. 3. Licensed nurses will be educated that residents that [redacted] need to have a smoking assessment and care plan. Staff will be educated that residents [redacted] are stored and secured appropriately. Unit Manager or designee will complete an audit of residents that [redacted] to assure that a [redacted] assessment has been completed, a care plan has been initiated, and residents that [redacted] do not have [redacted] in their possession. 4. These audits will continue weekly x 4, then monthly x 2 months then re-assessed. Results will be reviewed at Monthly QAPI.	

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F 689	Continued From page 2	F 689		

identified as a [redacted] would have [redacted] evaluation completed. The RN/UM stated the [redacted] evaluation assesses the resident's cognitive status, behaviors, ability to locate the designated [redacted] area and any history of unsafe [redacted] habits. The RN/UM further stated that staff also assessed whether the resident could hold, [redacted] and discard a [redacted] properly. The RN/UM stated that some residents were allowed to keep their own [redacted], and that residents are not allowed to keep their own [redacted]. The RN/UM stated that the facility has a [redacted] that was kept at the front desk and that the [redacted] remained with staff during [redacted] break.

During an interview with Resident #63 on 09/24/20 at 10:18 AM, Resident #63 stated that he/she had been [redacted] for a while and went out daily during [redacted] breaks. The resident did not provide specific date he/she started [redacted]

During a follow up interview with the RN/UM on 9/24/20 at 10:56 AM, she stated that Resident #63 recently started [redacted] at the beginning of September 2020 and that the [redacted] evaluation was the only evaluation on file for the resident.

On 9/24/20 at 2:33 PM, the surveyor went to the [redacted] area and observed residents during their scheduled [redacted] break time in the presence of the Assistant Director of Activities (ADA), who was assigned to monitor the afternoon [redacted] break session. The surveyor observed the ADA open door to the designated [redacted] area. The ADA then used a hand-held [redacted] the [redacted] of the first two

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F 689	Continued From page 3	F 689		

residents in line as they entered the smoking area. The surveyor observed that the ADA did not light the [redacted] of three residents including Resident#63. Once in the designated [redacted] area, the surveyor observed Resident #63 remove a [redacted] from his/her pocket and lit his/her [redacted] and then lit the [redacted] of three other residents in the area. At that time, the surveyor interviewed the ADA who acknowledged that Resident #63 usually lit other residents' [redacted]s because of social distancing. The ADA further stated that Resident #63 routinely lit his/her own [redacted].

During an interview with the Certified Nursing Assistant (CNA #2) on 9/29/20 at 10:15 AM, CNA #2 stated that she regularly worked on the [redacted] unit and that assignments were switched monthly. CNA #2 stated that Resident #63 was independent and would ask staff for assistance as needed. CNA #2 further stated that Resident #63 was [redacted] and was able to ambulate with cane to the [redacted] area. CNA #2 stated that the resident was compliant with abiding by [redacted] schedule.

During a follow-up interview with the ADA on 9/29/20 at 11:41 AM, the ADA stated that residents who [redacted] usually had a [redacted] assessment completed. The ADA further stated that he followed the [redacted] list (a list that documents the names and room numbers of residents who [redacted]) and that Resident #63 was recently added to the [redacted] list. The ADA stated that residents who were not listed on the [redacted] list were not allowed into the [redacted] during [redacted] breaks.

During an interview with the Recreation Director

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F 689	Continued From page 4 (RD) on [redacted] at 12:08 PM, the RD stated that she in-serviced staff assigned to monitor [redacted] break sessions about the [redacted] policy and procedures. The RD further stated that [redacted] list was updated as needed and that Resident #63 recently decided to pick up [redacted] this month of September. The RD stated that the facility policy indicated that residents were not allowed to keep persona[redacted] The RD further stated that if a resident was found with a [redacted], that staff should confiscate the [redacted] immediately and educate the resident on policy. The RD stated that nursing staff should complete a [redacted] assessment and update the care plan. The RD added that Resident #63's assessment was initiated on [redacted]. The surveyor reviewed Resident #63's [redacted] Care Plan Meeting note (note) with the effective date of [redacted] The note reflected that Resident #63 was a[redacted] and followed the facility [redacted] policy. The note also indicated that the CP was reviewed and was appropriate. There was no [redacted] care plan initiated until [redacted] During an interview with the Center Nurse Executive (CNE) on 9/29/20 at 1:20 PM, she stated that [redacted] evaluation was completed for [redacted] on admission, quarterly, and if there was a change in condition. The CNE further stated that [redacted] CP was initiated once a resident started to [redacted] and was usually addressed during the IDCP (interdisciplinary care plan meeting). The CNE confirmed that Resident #63's [redacted] CP was initiated on [redacted] and not on [redacted]. On 9/24/20, the CNE stated that social services (SS) met with the resident and discussed the rules and informed that residents were not allowed to keep [redacted]	F 689		

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F 689	Continued From page 5 after surveyor inquiry. The CNE stated if staff saw a resident with a [redacted], she expected them to confiscate the [redacted] During an interview with the Social Service Director (SSD) on 9/29/20 at 1:30 PM, the SSD stated that [redacted] assessments were generated by nursing on admission and as needed. The SSD further stated that staff supposed to review the facility [redacted] policy with the resident to make sure the resident understood. During an interview with the Center Executive Director (CED) on 9/30/20 at 11:47 AM, in the presence of the CNE and other surveyors, the CED stated that Resident #63 was fairly new to the [redacted] club and was not educated properly. When the surveyor questioned about the [redacted] Note where the resident was identified as a [redacted]. The CNE stated she was unable to locate any previous [redacted] evaluation or CP for Resident #63. A review of the facility's OPS137[redacted] policy, with the review date of 11/4/19, revealed patients would be assessed on admission, quarterly, and with change in condition for the ability to [redacted] safely. The policy further revealed that a patient's [redacted] status would be documented in the CP and updated as necessary. The policy reflected that patients were not allowed to maintain their own [redacted]. NJAC 8:39-27.1(a)	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		10/30/20

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F 761	Continued From page 6 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation, it was determined that the facility failed to ensure that all drugs and biologicals used in the facility are stored in accordance with professional standards, including removing of expired medications and biologicals from the medication room cabinets. This deficient practice was identified in 1 of 2 medication rooms inspected and was evidenced by the following: On 09/21/2020 at 12:28 PM, the surveyor inspected the Medication Room (med room) on	F 761	1. Expired medications, biologicals, and equipment were immediately disposed of. 2. Residents are at risk for this deficient practice. 3. The 11-7 Supervisor or designee will perform weekly Audits on medication storage areas, including med carts, to ensure that medication, biologicals, and equipment are not expired. Audits will be conducted by 11-7 supervisor or designee.	

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F 761	Continued From page 7 [redacted] unit in the presence of a unit nurse - Licensed Practical Nurse (LPN#1). The surveyor observed the following: 1. A box containing two vials of [redacted]. The vial with a blue top was labeled "high" and had an expiration date of 9/12/20. The vial with a white top was labeled "low" and had an expiration date of 9/11/2020. The outside of the box was dated 7/15. When interviewed regarding "7/15", LPN#1 who was with the surveyor during the inspection, stated that "7/15" was the open date of the solutions, and clarified that the solution was opened on 7/15/2020. The review of manufacturer's guide on [redacted] solutions indicated not to use expired solutions and to discard unused solutions three months after the vial was opened. 2. There was a plastic Ziploc bag with [redacted] of [redacted]). The surveyor noted that 4 of [redacted] expired in August 2020, while 8 [redacted] were not yet expired. All the [redacted] were mixed together in one Ziploc bag. 3. Fifteen [redacted] of [redacted] were found in a basket inside a cabinet in which 13 [redacted] expired on 6/2019 and two [redacted] expired on 3/2019. 4. One Ziploc bag containing [redacted] is an [redacted] medication used to keep [redacted]. There were 17 syringes of	F 761	4. Weekly audits x 4 weeks, then monthly audits x 2 months then re-assessed. Audits will be reviewed at our monthly QAPI.	

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the [redacted] inside the bag. Seven of 17 syringes were not yet expired, while 10 syringes expired on 8/31/20. All the syringes were stored together in one zip lock bag.

5. [redacted] which expired in June 2020, was found in a basket on the shelf among other items.

6. Three [redacted] specimen bottles [redacted] that expired in March 2003 (this is container with reagent used to collect [redacted] sample). There were four other bottles of the same [redacted] specimen bottles that expired in July of 2020.

On 09/21/20 at 01:07 PM, the surveyor interviewed LPN#1 who is a unit medication nurse. He stated that staff rarely used the supplies in the medroom and that the supplies were stored in the med room "just in case staff needed them." LPN#1 stated that staff usually obtained their supplies from the central supply room on the second floor. LPN#1 added that laboratory staff occasionally obtained supplies from the medroom if they ran out of their own supplies and all staff members were irresponsible for checking the medroom to ensure that medical supplies were not expired and remove expired items from the medroom.

On 09/24/20 at 10:07 AM, the surveyor interviewed RN#1 on [redacted] unit. When asked about the use of medical supplies from the medication room, RN#1 stated that she usually obtained supplies from the medroom, and if there wasn't any, she would then go to the central supply.

On 09/29/20 10:52 AM, the surveyor interviewed

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F 761	Continued From page 9 the resident's nurse, LPN #2 regarding the use of medication room. LPN#2 stated that she would obtain supplies from the medroom if she needed supplies for resident's care. She also stated that the night shift nurses were responsible for checking and removing expired items from the shelf. The surveyor reviewed the medroom storage policy dated 12/02/2017 and titled: "Storage and expiration Dating of medications, Biologicals, Syringes and Needles." The policy reflected that the facility should ensure that medications and biologicals that had been retained longer than recommended by manufacturer, should be stored separate from other medications/biologicals until destroyed or returned to the pharmacy. The Policy also indicated that the facility should destroy outdated/expired medications or biologicals. On 09/30/20 at 11:38 AM, during interview with the Director of Nursing (DON), she stated that staff was supposed to remove expired items from the medication cabinet in accordance with facility policy.	F 761		
F 812 SS=F	NJAC8:39-29.4(h) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		10/30/20

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F 812	Continued From page 10 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation, it was determined that the facility failed to a.) store, label and date potentially hazardous foods in a manner to prevent food-borne illness and b.) maintain and record refrigerator temperatures. This deficient practice was observed on 09/21/2020 at 09:55 AM, during the initial kitchen tour in the presence of the Food Service Director (FSD), and was evidenced by the following: 1. On a stainless steel shelving unit in the center of the kitchen was one plastic scoop in a 10 pound bag of flour that was half full and one plastic scoop in a 10 pound bag of sugar that was less than half full. 2. Walk in refrigerator temperatures not checked or documented on the logs in the evening of 9/20/2020 or the morning of 9/21/2020. 3. In the walk in refrigerator on the top shelf were two 32 ounce jars of chopped garlic that were opened and half used with no received, opened or use by date. 4. In the walk in refrigerator on the second shelf	F 812	1. Scoops were immediately removed from both containers in the presence of the surveyor, the flour and sugar were discarded and the containers were clean and sanitized. The corrected action that took place was scoops and scoop holders were ordered. Walk-in temperatures were taken and recorded right away. The condiment jars were disposed of immediately in front of the surveyor by the Account Manager.Chicken was disposed of properly and replaced. 2. Residents have the potential to be affected by these deficient practices. 3. Staff were in-serviced on proper storage and procedure of scoops and scoop holders to prevent cross contamination. Staff were in-serviced on proper taking and recording of all temperature logs as per policy. Staff were in-serviced on proper label and dating as per policy. Staff were in-serviced on proper thawing of meats as stated per	

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F 812	Continued From page 11 was one opened gallon container of relish with no received, opened or use by date, and one opened gallon container of Italian salad dressing with no received, opened or used by date. 5. In the walk in refrigerator on the bottom shelf was one deep plastic gray tray that contained five clear storage bags of completely thawed chicken pieces. In the bottom of the tray was approximately one quarter inch of light red liquid. There were no pull dates or use by dates on the chicken. On 09/21/2020 at 10:30 AM, the surveyor interviewed the Food Service Director (FSD) regarding dating of items. The FSD told the surveyor stickers are available for the staff to use and all items should be dated. The FSD told the surveyor that the chicken that was observed was pulled from the freezer by the cook that morning of the initial tour and should have been dated. On 09/21/2020 at 10:38 AM, the surveyor interviewed the cook regarding the thawed chicken. The cook told the surveyor that normally he would label it with a"pull date" when it is taken out of the freezer but that he forgot to put a label on the chicken that particular day. On 09/21/20 at 01:18 PM, the surveyor reviewed the policy titled "Use by" dating guidelines. The policy had a revision date of 12/1/15. Under the section of refrigerator it was written that chicken that is placed in the refrigerator to thaw would be dated with a use by date of 1-2 days. On 09/23/20 at 12:47 PM, the surveyor reviewed the policy titled Refrigeration/freezer temperature standards. The policy was revised 12/1/2015. The policy indicated that the FSD or designee	F 812	policy. 4. Audits of scoops, temperature recording, and dating of products will be done by the Account Manager or designee. Audits will be completed weekly x 4 weeks, then monthly x 2 months . Audits will be reported at our monthly QAPI.	

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F 812	Continued From page 12 observes and records the temperatures of refrigerators and freezers on using the refrigerator/freezer temperature log. The surveyor then interviewed the FSD who told surveyor the facility checks the refrigerator temperatures every morning and every evening. The FSD could not say why the logs were not checked for the two dates and times. On 09/30/20 at 09:50 AM, the surveyor reviewed the Food Storage and Retention Guide. The section titled Shelf Stable Foods indicated that condiments (salad dressing and relish) could be in dry storage for 12 months and once opened could remain in the refrigerator for 3 months when stored below or equal to 41 degrees F. NJAC 8:39-17.2 (g)	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable	F 880		10/30/20

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diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 14 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical record and other facility documents, it was determined that the facility failed to follow facility policy to ensure that Personal Protective Equipment was utilized consistently to minimize the potential spread of infection during a.) lunch meal distribution to residents and b.) video conferencing. This Deficient practice was identified for 2 staff members and on 1 of 3 nursing units and was evidenced by the following: 1. On 09/21/20 at 9:39 AM, the surveyor interviewed the Center Executive Director (CED) who stated that a portion of [redacted] unit was utilized for residents who were newly admitted/re-admitted to the facility and/or received [redacted] who were maintained on observation status in private rooms in order to minimize the potential spread of infection of COVID-19. The CED further stated that Personal Protective Equipment (PPE) (garments or equipment worn to protect the body from infection) which included an N-95 Mask (particulate-filtering mask), face shield or goggles, gown and gloves were required in order to enter the aforementioned resident rooms.	F 880	1. Staff are wearing appropriate PPE while delivering meal trays, video conferencing. 2. Residents on transmission-based precautions are at risk for this deficient practice. 3. Staff will be re-educated to don/doff appropriate PPE when entering and exiting resident rooms on precautions. IP or designee will audit for compliance. 4. Audit for PPE donning/doffing to be completed weekly by IP or designee x 4 weeks, then monthly x 2 months. Audits will be reported at our monthly QAPI. We will reassess as needed at monthly QAPI.	

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At 1:17 PM, the surveyor entered the unit through double doors on [redacted] Nursing Unit and noted signage affixed to residents' room doors which were maintained closed. The signage was a Stop Sign which cautioned: "Patient-Specific Contact Plus Airborne Precautions for special respiratory circumstances please see the nurse before entering the resident's room." The instructions specified that an N-95 Respirator (a particulate-filtering face mask that filters 95% of airborne particles), gown, face shield and gloves were required to enter the room.

The surveyor observed a Certified Nursing Assistant (CNA) #3 who wore a KN-95 Mask (particulate-filtering mask) and goggles as she obtained a lunch tray from the food cart located outside of the double doors. CNA #3 proceeded to deliver the meal tray without first donning (applying) a gown and gloves before she entered a resident's room even though the room had cautionary signage affixed to the door, specifying that the resident was on Contact Plus Airborne Precautions. The surveyor observed CNA #3 perform hand hygiene using alcohol-based hand rub (ABHR) after she exited the resident's room.

At that time the surveyor interviewed CNA #3 who stated that she worked for an outside agency. She stated that she was not sure if the portion of the unit where she distributed meals was utilized for quarantine or for isolation of residents. She also added that she did not know if she was required to wear gown and gloves for meal tray distribution or not. She further stated that she had not receive direction from nursing staff prior to her shift. Review of facility

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in-service training showed that CNA#3 had training on proper PPE use on the units. The signage on the doors also explained the required PPE for the resident rooms.

The surveyor observed CNA #3 deliver two additional meal trays to residents' rooms wearing a KN-95 Mask and eye goggles and she did not donn a gown, face shield or gloves as the signage indicated. The CNA did perform hand hygiene after each meal tray delivery.

At 1:24 PM, the surveyor interviewed the Unit Manager (UM), a Licensed Practical Nurse (LPN/UM #1) who stated that the assigned nurse was responsible to delegate required PPE use for meal pass to the CNA. The surveyor noted a cart located next to the entryway of the double door which contained the required PPE and it was accessible to all staff.

At 1:25 PM, the surveyor interviewed the Registered Nurse (RN) #1 who stated that CNA #3 was instructed to donn both gown and gloves before she delivered meal trays. RN #1 then instructed CNA #3 to donn a gown and gloves before she delivered another meal tray. CNA #3 obtained another meal tray, opened the door to a resident's room and without going into the room handed the tray to another staff member with full PPE who was present inside the doorway of the resident's room.

RN #1 stated that CNA #3 had been educated along with all staff by the Staff Educator numerous times that a gown and gloves were required to be worn in addition to an N-95 Mask and protective eyewear on this section of the unit within isolation rooms. Review of facility

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in-service training showed that CNA#3 and all other staff members had training on proper PPE use on the units.

RN#1 also stated during another interview with the surveyor on 10/7/20 at 12:12 PM, that she provided oversight to CNAs to ensure they wore proper PPE. RN#1 confirmed that she had observed and reported CNA#3's non-compliance once to the Assistant Director of Nursing (ADON) prior to the 9/21/20 observation by the surveyor and that the Staff Educator who served as the Infection Preventionist (IP) provided re-inservce to CNA#3 at the time.

On 9/23/20 at 11:56 AM, the surveyor interviewed the CED who stated that staff were required to wear full PPE, with gown and glove changes and to perform hand hygiene after each meal tray was delivered. He further stated that agency staff received the same training as facility staff.

At 12:47 PM, the surveyor interviewed the Center Nurse Executive (CNE) who stated that staff who did not have direct resident contact, but who enter the room of a resident on Contact and Airborne Isolation for quarantine and dialysis unit, were required to wear a face shield, N-95 Mask, gown and gloves.

On 09/29/20 at 12:04 PM, the surveyor interviewed LPN/UM #1, who stated that all CNA's were required to wear an N-95 Mask, gown, gloves, and face shield during meal tray pass. She further stated that staff were required to remove PPE and wash their hands before going to the next room. LPN/UM #1 stated that she was not aware that CNA#3 has had issues

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with non-compliance in wearing appropriate PPE. No other saff reported concerns regarding CNA #3's use of appropriate PPE.

At 1:35 PM, the surveyor interviewed the Infection Preventionist (IP) who stated that when staff distributed meal trays to residents who were in a Contact/Airborne Precautions room, they were required to wear a gown, gloves, face shield and N-95 mask. She stated that everyone was expected to perform hand hygiene each time they removed their PPE. She further stated that the potential risk of contamination from room to room was possible if required PPE was not worn.

On 09/23/20 at 12:32 PM, the CNE provided the surveyor with an In-Service Sign-in Sheet dated [redacted], with the Topic: Meal Tray Pass during COVID-19 which revealed that CNA #3 received education. The in-service specified that:

Nurse aide (s) and nurses will be assigned to deliver trays to suspected, presumed, or confirmed positive COVID-19 patients.

The Nurse aide and nurses passing trays to these patient rooms will wear a gown, gloves, N95 respirator, and a face shield when passing the meal trays.

Further review of the facility documentation reflected that the facility removed CNA #3 from the schedule for [redacted] and also submitted a formal letter of termination of employment to CNA#'s outside agency on [redacted].

During interview with the facility IP on 10/7/20 at 10:18 AM, the IP stated that she also conducted oversight on staff compliance with wearing

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F 880	Continued From page 19 appropriate PPE. The IP provided a document titled: Covid-19 walking/virtual Rounds for Infection control. The rounding document showed daily walking rounds of units and one episode when a staff member was re-educated by the IP regarding the use of proper PPE during the month of September. 2. A review of the Admission Record revealed that Resident #53 was admitted to the facility with diagnoses that included: [redacted] Review of the quarterly MDS dated [redacted], revealed that the resident was rarely understood and was [redacted] cognitively impaired. The MDS specified that the resident required total dependence of two persons for transfers and that the resident had a [redacted] and required [redacted] Review of Resident #53's Care Plan revealed an entry that was revised on [redacted], which indicated that the resident had the potential for infection/[redacted] and was at risk for infection. The care plan indicated that the resident was at High Risk due to frequent medically necessary care outside facility[redacted] and that Resident#53 was on Contact Plus Airborne Precautions. On 09/22/20 at 1:15 PM, the surveyor approached the room of Resident #53 and saw a signage affixed to the outside of the door which indicated that the resident was on Contact Plus Airborne Precautions and all who entered the	F 880		

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room must donn an N-95 Respirator, gown, face shield, and gloves prior to entry.

The surveyor entered the room and observed the Social Services Director (SSD) seated in a chair at the bedside in the resident's room. The SSD wore a KN-95 Mask and goggles but did not wear a face shield, gown or gloves. When interviewed, she stated that she was there to conduct a video conference between the resident and a family member. The surveyor observed a tablet computer which was set up in a freezer bag on the resident's over bed table.

At 1:19 PM, the surveyor interviewed the SSD who stated that a mask, goggles and gown were required to enter the resident's room but she could not find a gown. She stated that while she did not wear gloves during the video conference in the resident's room, she wore mask, goggles and performed hand hygiene.

During another interview with the SSD on 10/7/20 at 11:32 AM, she stated she did receive education education about PPE use and that Resident #53 was not newly readmitted to the facility and as such, she looked at the resident differently with regard to wearing face shield. The SSD stated that she did not see any other resident after Resident#53. The SSD also stated that she was re-inserviced by the IP following the above incident.

On 09/23/20 at 10:21 AM, the surveyor interviewed the Infection Preventionist (IP) who stated that Resident #53 was on [redacted] and required Contact Plus Airborne Precautions per protocol. She further stated that when the SSD entered the resident's room she was supposed to

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F 880	Continued From page 21 donn a gown, gloves, face shield and N-95 mask to conduct the video conference in an isolation room to prevent contamination. On 09/23/20 at 12:47 PM, the surveyor interviewed the CNE who stated that whoever entered isolation rooms and rooms of residents on [redacted] were required to wear a face shield, N-95 mask, gown and gloves and hand hygiene was required to prevent the spread of infection regardless of having direct contact with the resident or not. Review of Resident #53's Lab Results Report dated [redacted] at 12:42 PM, revealed that the resident's [redacted]. Review of Practitioner Note dated [redacted] at 4:24 PM, revealed that Resident #53 had confirmed [redacted]. The CNE provided the surveyor with an in-Service Sign-in Sheet dated [redacted], which indicated that the SSD received training on: Guidance on expanded use of K-N95 Masks, New Precaution Signs, Hand Hygiene and Safe Practices and PPE for Health Care Personnel per Centers for Disease Control Guidance which contained a copy of the Extended Contact and Airborne Precautions and all requirements for PPE usage within resident rooms. The surveyor reviewed the facility policy, " IC301 Contact Precautions" (Revision Date 06/15/19) revealed the following:	F 880		

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F 880	Continued From page 22 In addition to Standard Precautions, Contact Precautions will be used for diseases transmitted by direct or indirect contact with the patient or the patient's environment. to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact and that staff must use barrier precautions when entering the room, including to wear a gown and gloves. NJAC 8:39-19.4	F 880		